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Grace Buchloh 4/19/2020

Approval Sheet

"Si Usted Quiere, Aqui Estoy": A Special Studies Project Supporting IPV Care Provision in One Centro de Salud Familiar in Santiago, Chile

By

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Abstract Cover Page

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By

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Bachelor of Arts in International Relations and Women's, Gender, and Sexuality Studies
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An abstract of
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Abstract

"Si Usted Quiere, Aqui Estoy": A Special Studies Project Supporting IPV Care Provision in One Centro de Salud Familiar in Santiago, Chile
By: Grace Buchloh

IPV is a global public health concern, as it is one of the leading causes of injury and disability for women, and has long-term intergenerational consequences for the health and wellbeing of children and families. To combat the global epidemic of intimate partner violence (IPV), screening procedures have been designed and implemented in a wide variety of clinical contexts, and Chile is no exception. This project aims to bolster screening and referral consistency, efficiency, and efficacy at CESFAM Recoleta, a public, primary care center, in Santiago, Chile, by 1) Mapping the current IPV screening and referral process used by clinic midwives and making targeted process improvement recommendations and 2) Using the perspectives garnered in the formative research project from summer 2019 to inform the creation of training content for providers and outreach materials for patients. The research team conducted semi-structured, in-depth, key informant interviews with seven staff members at the CESFAM Recoleta clinic (five midwives, one social worker, one psychologist) and three pregnant or formerly pregnant patients with either current or past experience of IPV. The qualitative, key-informant interviews conducted highlighted some general themes around IPV care provision in the CESFAM. The themes were compiled, along with formal recommendations, and relevant training resources, in a IPV Manual for CESFAM Recoleta. The approach and process changes recommended are slated to improve the consistency and standard of care through routine training of providers and standardization of competencies and IPV referral processes. Shifts in the clinic's approach to and readiness for care may reduce rates of provider burnout, and improve disclosure rates and health outcomes for patients.

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Abbreviations

CdlM	Centro de la Mujer
CESFAM	Centro de Salud Familiar
COSAM	Centro de Salud Mental
EGHI	Emory Global Health Institute
EPSA	Evaluación Psicosocial Abreviada
IPV	Intimate Partner Violence
LARC	Long Acting Reversible Contraceptive
PCW	Power and Control Wheel
SERNAM	Servicio Nacional de la Mujer
WAST	Woman Abuse Screening Tool

Chapter 1: Introduction and Project Background

Rationale

Intimate partner violence (IPV) is defined by the WHO as "any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship," (WHO, 2012). Globally, IPV affects 35% of the female population (WHO, 2017). It is a global public health concern, as it is one of the leading causes of injury and disability for women, and has long-term intergenerational consequences for the health and wellbeing of children and families (Bott, Guedes, Goodwin & Mendoza, 2012). IPV has grave consequences on an individual's mental and physical health, and it is associated with a wide range of adverse outcomes such as physical injuries, anxiety, depression, and suicidal ideation (Leon, Grez, Prato, Torres, & Ruiz, 2014). Women who experience IPV are at serious risk of loss of life from femicide or suicide (Leon, et al., 2014; Guajardo & Cenitagoya, 2017). During pregnancy, IPV is associated with a host of adverse health outcomes to both the woman and the baby, (Ogbonnaya, Macy, Kupper, Martin, & Bledsoe-Mansori, 2013), including an increased risk of low-birthweight, preterm, or small for gestational age babies (Chisholm, Bullock, & Ferguson, 2017), and maternal and neonatal death (Alhusen, Ray, Sharps, & Bullock, 2015).

While IPV affects women across demographics, demographic factors such as young age and low socioeconomic status are associated with higher rates of IPV (Sugg, 2015). Other risk factors for experiencing IPV as a woman include experiencing abuse in childhood, being an immigrant, or being unemployed (Sanz-Barbero, Baron, & Vives-Cases, 2019). Risk factors for males perpetrating violence appear to also include low socioeconomic status and unemployment, as well as gang membership, substance use, and exposure to IPV violence as a child (Fleming et al., 2015; Krishnan et al., 2010). All of these factors are situated within a complex matrix of

societal views, practices, and norms, that vary dramatically across contexts, requiring all IPV-reduction efforts to be targeted to each specific community (Heise, 1998).

Intimate Partner Violence in Chile

IPV prevalence in Latin America mirrors prevalence rates in other parts of the globe (WHO, 2013). In Chile, IPV is a widespread and serious problem that has gained the attention of social scientists and law-makers alike in the country (Larrain, 2009; Bacigalupe, 2000). The pervasiveness of intimate partner violence in Chile is informed by a complex array of social and historical factors. While there are many cultural nuances across countries in Latin America, broadly speaking, Latino culture has been found to value adherence to strict gender norms, often called machismo culture (Galanti, 2003; Rivera et al., 2008). While the presentation of machismo is complexly constructed and diverse across Latin America (Torres, Solberg, & Carlstrom, 2002), it is suspected that, overall, machismo culture perpetuates violence by valuing potentially harmful traits in males, such as aggression and exercising dominance over women (de la Rubia & López Rosales, 2013). Its converse, marianismo, prescribes ideal female characteristics as devoted, self-sacrificing, compliant, and submissive (Galanti, 2003).

Other important cultural dimensions in Chile may impact the normalization of gender-based violence, such as the national religion. In Chile, the predominance of Catholicism, a religious institution with deeply rooted norms around gender inequity, and has an incalculable impact on the country's culture as it pertains to sexual and gender roles, and the values of the governing bodies as they pertain to resource provision around the education and eradication of gender-based violence (Lehrer, Lehrer, & Krauss, 2009). In Chile, religion and the role of the State are intimately tied, and the Catholic church as adversely affected Chile's policy-making around issues the affect women experiencing IPV, such as outlawing divorce until 2004, and

imposing restrictions on accessing emergency contraception (Guzmán, Seibert, & Staab, 2010; Lehrer et al., 2009). The state also plays a critical role in shaping the legal and social environment for women experiencing abuse through the institutionalization of conservative values in family law (Guzmán et al., 2010), setting funding priorities for resources and anti-violence campaigns, and creating a political environment unfriendly to immigrants and undocumented individuals.

Finally, Chile is an increasingly diverse country, having the highest immigration rate in Latin America from 2010 to 2015 (Reveco, 2018), with growing numbers of immigrants coming from countries experiencing political and economic instability, like Haiti, Bolivia, and Venezuela ("Estadisticas Migratorias," 2020). Chile also ranks third for level of income inequality in the world (OECD, 2018). While the mechanism is not entirely understood, research has shown that a state's level of income inequality impacts the risk of IPV (Rashad & Sharaf, 2016), possibly because large wealth disparities increase overall senses of frustration and anxiety that can lead to generally more violent behavior (Enamorado, López-Calva, Rodríguez-Castelán, & Winkler, 2016). Regardless of a state's level of income inequality, immigrant status and low socioeconomic status are both risk factors for IPV. Additionally, these demographic conditions also complicate the feasibility of utilizing standard, state-based processes of leaving an abusive partnership, such as filing restraining orders and taking an abuser to court, as these institutions, such as law enforcement, can be a direct threat to a vulnerable person's safety and stability.

Socio-political context

This project is as relevant as ever. Beginning in October of 2019, a grass-roots, student led uprising began in Santiago and other cities across Chile in response to the implementation of policies seen to exacerbate the already egregious level of wealth inequality in the country.

Overall, the protests are changing the dynamic between the public and the private spheres, as they pertain to personal grievances and injustices due to “small” changes in policies (like a four cent fare hike to ride the metro in Santiago), by mandating a swift and dramatic change in tone and policy around issues that affects individuals with marginal amounts of power. Chileans, along with many across the world, have also demanded a national conversation around sexual assault, as part of the #Metoo movement (Remnick, 2019), though with comparably less success than the outcry from the fare hike. Additionally, the global shift toward xenophobia and isolationism has exploded anti-immigrant sentiments around the world, and Chile is no exception ("Chile gives immigrants a wary welcome," 2018). The present tone of volatility in the interactions between the public and private spheres in Chile and the hostility and tensions that result, make the work of educating and capacitating medical providers who are interfacing with vulnerable populations and discussing the complex, stigmatized topic of IPV daily an even more vital task.

Clinical Interventions For IPV

As a result of the physical/emotional harms of IPV, various interventions have been attempted, often with the expressed purpose of reducing the overall incidence of IPV in the patient population. One of the most common clinic-based interventions aims to identify IPV patients and connect them to IPV-specific resources through a standardized screening and referral process (Alvarez, Fedock, Grace, & Campbell, 2017; O'Doherty et al., 2015). The clinic-based screening approach leverages the patient-provider connection to begin engaging in a dialogue around the ways IPV can look between partners, its unacceptability, and to link the patient to local IPV resources. It provides a space for the employment of harm reduction techniques, such as collaborative decision-making around LARC placement as a strategy to

covertly fight against reproductive coercion, and also seeks to prevent adverse prenatal outcomes by providing pathways to IPV-specific care during the vulnerable time of pregnancy (Grace et al., 2020).

Unfortunately, achieving the desired outcome of a reduction in IPV incidence through the use of screening-based clinical interventions appears to be difficult to realize (Taft & Colombini, 2017). Successful service delivery of IPV resources to patients often requires a synchrony between providers, administrators, and external resources, and a commitment to training and retraining practitioners on best-practices on IPV care and referral that would be functionally impossible for most health systems to achieve. The complexity of IPV, with its sources and solutions so deeply embedded in social and economic phenomena and constraints, limits the control that providers and patients have in reducing its incidence (Trabold, McMahon, Alsobrooks, Whitney, & Mittal, 2018), and many clinical trials have found that clinic-based IPV screening and referral interventions are ineffective at reducing the re-exposure to violence (O'Doherty et al., 2015).

However, despite these interventions' inefficacy in reducing the incidence of IPV, there is evidence to suggest that patients desire to be screened by their midwives during primary or maternity care (Garnweidner-Holme, Lukasse, Solheim, & Henriksen, 2017; Rivas, Vigurs, Cameron, & Yeo, 2019) and that the successful implementation of a robust and integrated clinic-based screening and referral intervention for IPV leads to a variety of under-valued secondary outcomes, such as safety planning, push-back to reproductive coercion, mental wellness, and use of community resources (Taft & Colombini, 2017). Positive interactions with providers around the topic of IPV can increase a patient's recognition that she is deserving of better treatment,, and improve her sense of self efficacy and agency all of which can improve a patient's mental

wellness and increase the likelihood of utilizing services (Chang et al., 2010; Hegarty et al., 2013).

IPV Care in Chile

As a result of the high prevalence of IPV, leaders across Chile have been investing time and financial resources into bolstering support for women experiencing IPV. Studies estimate that IPV in Chile costs the country between 1.6% and 2% of GDP annually through the loss of women's earnings and productivity (Orlando, 1999). To address this significant issue, Chile has dedicated a governmental organization for the promotion of gender equality and women's services, the Servicio Nacional de la Mujer y la Equidad de Género (SERNAM) (McWhirter, 1999). This agency provides legal guidance, psychiatric and social care, as well as safe houses for women trying to leave an abusive partner and is a referral destination for public healthcare clinics providing services to women experiencing IPV.

One site of routine gynecologic and prenatal care in Chile for women with lower incomes is a network of public medical centers called Centro de Salud Familiar (CESFAM), which are split up into districts. These facilities provide the vast majority of the general primary medical care to low-income families in urban areas across Chile. CESFAMs employ midwives, primary care physicians, psychiatrists, psychologists, social workers, and provides referrals to external resources for specialty care. IPV-related care in the CESFAMs is provided by a triad of providers: the midwives, psychologists, and social worker. For pregnant patients, midwives serve as the first point of entry into the clinic, and these midwives serve as funnels to additional services, both inside and outside the clinic, conducting screenings, making referrals, and following up with patients.

Overall, midwives in Chile are foundational to the provision of reproductive and women's health services, providing reproductive health care for 80-90% of the female population (Binfa, 2011; Segovia, 1998). Thus, they are uniquely positioned to serve as connectors between IPV survivors and IPV support services. The partnership based care, essential to the midwifery model, could be essential in creating space for the woman to trust and disclose her history (Battaglia, Finley, & Liebschutz, 2003).

Project Background

To begin exploring the feasibility and efficacy of a clinic-based IPV screening and referral protocol in an urban CESFAM in Santiago, a collaborative research project took place between Emory University and the University of Chile in Santiago in summer of 2017. The research team collaborated with CESFAM leadership and staff to pilot a screening tool called the Woman Abuse Screening Tool (WAST) in the CESFAM in Recoleta district, to capture an IPV prevalence of the patients being seen by the clinic's midwives. All of the patients are CESFAM Recoleta are low-income, and a majority are immigrants from Haiti, Bolivia, and Venezuela.

The study found that most women who screened positive for IPV by their midwives, and who were offered a referral to the clinic's social worker, psychologist, and to the local Centro de la Mujer, declined the referral. According to one of the researchers on the project, of the women who did seek care, most attended one visit and did not return. Upon review of the first study's findings, the researchers at the University of Chile research team requested a follow up project to explore the reasons for the low level of IPV resource utilization and for quality improvement measures to be implemented to improve the in-clinic screening procedure effectiveness.

A new team of Emory student researchers received a grant from the Emory Global Health Institute (EGHI) in 2019 to conduct a follow-up study, co-designed with the University of Chile

researchers. The research team conducted semi-structured, in-depth, key informant interviews with seven staff members at the CESFAM Recoleta clinic (five midwives, one social worker, one psychologist) and three pregnant or formerly pregnant patients with either current or past experience of IPV. The project objectives were to 1) Explore the experience of IPV survivors who declined a referral for services or did not access these services consistently, and 2) Explore the perspective of the midwives who provide referrals for IPV services on their perceptions of the non-use of IPV care.

The Chilean researcher collaborators on the project have asked for a key informant analysis of the interview data, for key findings from the interviews to be reported, and for recommendations to be made and resources developed to the clinic on appropriate actions to consider that would improve the delivery of care and referrals to patients experiencing IPV.

Problem Statement

In a population-based household survey in Chile, 24.9% of women reported IPV, but rates as high as 50% have been identified (Larrain, Valdebenito, & Rioseco, 2009). Despite the availability of IPV care in Chile, many women with IPV do not seek help, a well-known phenomenon among women survivors of IPV (Overstreet & Quinn, 2013). Although midwives are at the front lines in terms of screening and referring women for IPV care, especially for highly vulnerable populations, recent research identified a need to better equip midwives to provide comprehensive, accessible, and useful care to women experiencing IPV (Binfa, Pantoja, Gonzalez, Ransjö-Arvidson, & Robertson, 2011; Gomez-Fernandez, Goberna-Tricas, & Paya-Sanchez, 2017; Rojas, Rain, Cuadra, & Castanon, 2018).

Purpose Statement

The goal of this special studies project is to make clinic-specific, data-driven recommendations to clinic leadership at CESFAM Recoleta in Santiago, Chile, to improve the IPV referral competencies and processes of their midwives.

Objectives

The project aims to bolster CESFAM-Recoleta's screening and referral consistency, efficiency, and efficacy by:

1. Mapping the current IPV screening and referral process used by clinic midwives and make targeted process improvement recommendations
2. Using the perspectives garnered in the formative research project from summer 2019 to inform the creation of training content for providers and outreach materials for patients

Significance Statement

The clinic this project pertains to disproportionately serves low-income and immigrant patients, making this an ideal location for quality improvement of IPV screening and referral processes. The successful execution and long-term implementation of this project will strengthen CESFAM-Recoleta's clinic's provision of care to patients experiencing IPV by bolstering clinicians' confidence in conducting IPV screenings, and through other quality improvement means. It will also serve as a model for other clinics in the CESFAM network, able to be scaled up to other CESFAM clinics across districts, and tailored to addressed the unique needs of each clinic's population. This project's deliverables may also serve as a roadmap for future improvements the clinic wishes to make regarding IPV care provision to the diverse patient population they serve. While this project's approach does not target the underlying sources of violence between intimate partners, it is a critical step in the social response in ending the

cultural sanctioning of violence against women, and meets a tangible need that may have implications far beyond any immediate results.

Chapter 2: Literature Review

Introduction

IPV is a global scourge, affecting one in three women worldwide (WHO, 2017). Intimate partner violence is defined by the WHO as "any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship," and specifically includes acts of physical aggression, sexual coercion, psychological abuse, and controlling behaviors (WHO, 2012, p. 1). The WHO definition for IPV is used contemporarily due to its comprehensive approach to identifying abusive behaviors, including non-violent modes of abuse, such as psychological aggression, stalking, and reproductive coercion (Sugg, 2015). Historically, there has been an emphasis on the role of child abuse, rape, and spousal abuse in the field of IPV research, with less of an emphasis on non-violent forms of abuse or abuse between non-spouses and its implications (Plichta & Falik, 2001). The inclusion of non-violent forms of abuse in the definition of IPV and in research and policy-making around the topic of IPV promotes a comprehensive approach to the issue and encourages interventions that attend to the diverse needs of individuals experiencing a range of violent and/or abusive environments. Verbal aggression has also been found to be a predictor of future physical aggression among intimate partners (Schumacher & Leonard, 2005), further highlighting the importance of specifically attending to non-violent forms of abuse in the clinic space.

Overall, intimate partner violence prevention has been a growing priority in the field of public health, in large part due to the growing body of evidence regarding its long-term health implications ("WHO Guidelines Approved by the Guidelines Review Committee," 2013). However, a wide array of terms is used in the public health literature to explore abuse between intimate partners and to capture its health consequences. While IPV is used throughout this

paper, other terms commonly encountered in the literature include “gender-based violence,” “battering,” “domestic violence,” “domestic abuse,” “dating violence,” “intimate partner sexual violence,” and “sexual violence”. The use of these terms varies based on the scope of the study and the issue being explored. For example, domestic violence would include violence across generations in an inter-generational household to encompass child or elder abuse. The breadth of vocabulary used to address issues of violence between familiar individuals causes challenges for interpreting the data around prevalence, severity, and implications of violence. For this project, the term intimate partner violence is used, as the focus is on violence between sexual and/or romantic partners, regardless of their marital or cohabitation status. This emphasis is the result of both empirical and formative research indicating that the most common source of physical non-physical violence, or controlling behaviors, in Latin America is male intimate partners (Krug, Mercy, Dahlberg, & Zwi, 2002).

It must be noted that nearly all the data cited in this thesis use a hetero-normative lens and are focused on cisgender women, but there are data to suggest that IPV rates are much higher for transgender or gender non-conforming women (Garthe et al., 2018; Henry, Perrin, Coston, & Calton, 2018). While this project frames IPV in the context of cisgender women in Santiago, due to the preferences of our in-country partners and the project’s focus on IPV during pregnancy, further research on this topic and advocacy around clinical interventions related to IPV must consider the unique needs of all women and gender non-conforming individuals.

IPV and Health

The research around IPV is ubiquitous in its illustration of poor health outcomes for the women affected. IPV experience is associated with increased risk of overall poor health, chronic disease experience, substance abuse, and chronic mental illness (Coker et al., 2002; Leon, Grez,

Prato, Torres, & Ruiz, 2014; Plichta & Falik, 2001). Experiencing IPV is consistently associated with a poorer overall health status, and increased risk of disability and chronic conditions (Plichta & Falik, 2001). Women who experience IPV are also at risk for loss of life from femicide or suicide (Leon, et al., 2014; Guajardo & Cenitagoya, 2017).

There are also specific health implications for IPV during a pregnancy. IPV during the perinatal period leads to adverse maternal and infant health outcomes (Chaves et al., 2019). It is associated with adverse maternal mental health outcomes such as depressive symptoms (Ogbonnaya, Macy, Kupper, Martin, & Bledsoe-Mansori, 2013), preterm birth, low birth weight, small for gestational age (Chisholm, Bullock, & Ferguson, 2017a), bonding failure between other and newborn (Kita, Haruna, Matsuzaki, & Kamibeppu, 2016), and fetal injury, stress, or death (Dye, Tollivert, Lee, & Kenney, 1995). Once the child is born, data show that being raised in a household where violence is prevalent can cause PTSD symptoms among children (Boeckel, Wagner, & Grassi-Oliveira, 2017). Exposure to abuse in childhood has been associated with severe developmental deficits in children of the subsequent generation (Roberts, Lyall, Rich-Edwards, Ascherio, & Weisskopf, 2013). These cross-generational consequences make it even more critical for the field of public health to creatively explore ways to disrupt the cycle of abuse.

This research around IPV, on its health implications across the lifespan, and during pregnancy specifically, has illuminated a variety of hopeful points of entry for possible interventions. However, like all public health epidemics, IPV is situated within, and complicated by, a unique social context. IPV research has widely used the ecological framework approach to conceptualizing IPV, and the innumerable individual, relational, community, and structural factors that contribute to its prevalence and persistence (Yakubovich et al., 2018). Yakubovich et

al., in their systematic review of the longitudinal evidence of IPV risk factors, found strong evidence for two modifiable risk factors: unplanned pregnancy, and parents having less than a high school education, which is suspected to be a proxy for low socioeconomic status (2018).

Clinic-Based Screenings for IPV

The there is strong support for the contention that early detection of IPV is a critical first step to service provision (O'Doherty et al., 2015), and that social support at the community level can help offset the negative mental health effects of IPV (Dias et al., 2019; McCloskey et al., 2006). Compassionate and knowledgeable medical professionals such as doctors, nurses, and midwives are uniquely situated to provide education, support, and referrals to women experiencing IPV. In order to provide support and reassurance, however, women experiencing IPV need to be consistently and reliably identified. As a result, there has been a global push to increase the use of IPV screenings by healthcare providers, and to equip healthcare practitioners to provide IPV-specific resources or care in the event of a positive screening (Decker et al., 2012; Zaher, Keogh, & Ratnapalan, 2014).

While many public health efforts are underway to help achieve greater frequency and quality of screenings and referrals during patient-care (Alvarez et al., 2017; Furniss, McCaffrey, Parnell, & Rovi, 2007), there is also a body of literature attempting to measure the efficacy of these clinic-based interventions overall. Because of the complex nature of the IPV epidemic, studies measuring efficacy of screening interventions by their likelihood of reducing the incidence of violence or improving the health outcomes of survivors have found little evidence supporting the use of screening for those ends (DeGue et al., 2014; MacMillan et al., 2009). One RCT assessed women's knowledge and awareness of IPV and its solutions at baseline and one year after a clinic-based intervention, and found that there was no difference in knowledge

between women who were screened and given a resource list compared to controls (Klevens, Sadowski, Kee, & Garcia, 2015). A systematic review found that screenings alone appear to have no impact on number of referrals, re-exposure to violence, or on a litany of health impacts (O'Doherty et al., 2015).

Despite evidence that provider screenings and referrals often do not impact incidence of violence, when patients are consulted about the utility of provider-based IPV screenings and referrals, numerous studies show that patients express a desire to talk to their midwives about IPV (Garnweidner-Holme, Lukasse, Solheim, & Henriksen, 2017; Rivas, Vigurs, Cameron, & Yeo, 2019). The work by Rivas, Vigurs, Cameron, and Yeo shows that having conversations with patients about IPV, making referrals, answering questions, and opening a dialogue is valuable even if the patient is not ready to leave their abuser (2019). Other studies have shown that having a positive interaction with a medical provider through an IPV screening can benefit people experiencing IPV by increasing perceived senses of safety, support, and self-efficacy (Renner, Wang, Logeais, & Clark, 2019). Further, evidence shows that training providers on IPV and providing institutional support for screening and referrals leads to a greater number of IPV incidences disclosed (Feder et al., 2011). Evidence also suggests that IPV screenings can reduce depression symptoms, instances of violence, and in some cases improve pregnancy outcomes (Chisholm et al., 2017), and one RCT found that women who were screened and given a referral list were more likely to know that IPV is not the victim’s fault, compared to controls who only received a referral list.

While the applicability of these findings are limited due to their geographic contexts in highly developed, Western countries, the studies do suggest that by expanding the outcome measure for screening interventions to include outcomes such a positive, supportive dialogues

between patient and provider during a visit, the measured efficacy of clinic-based screenings becomes clearer, and its utility in helping put a patient on the path to additional support becomes apparent and, thus, more valuable. Women experiencing abuse navigate complex decision making around keeping herself and her family safe (WHO, 2012), and to dismiss the progress she might make in her thinking and safety because she remains with her abuser does not do justice to the her work or the work of the clinicians assisting her. Thus, the disconnect between the public health research findings about the utility of screenings and the difficult reality of those experiencing violence and abuse begs a reframing of the outcome measures for IPV research around screenings.

Conducting Clinic-Based Screenings

In order to reap the benefits of provider-based screening and interventions, providers must feel confident in their abilities to screen and refer. However, studies have shown that midwives do not feel adequately prepared to conduct screenings and referrals (Renner, Wang, Logeais, & Clark, 2019(Eustace, Baird, Saito, & Creedy, 2016; Mauri, Nespoli, Persico, & Zobbi, 2015; Mezey, Bacchus, Haworth, & Bewley, 2003). Specifically, providers list challenges to screening, such as tight time constraints, a lack of private time with patients, a lack of training around common signs and symptoms of IPV, the taboo nature of the topic, and staff shortages (Baird, Salmon, & White, 2013; Eustace et al., 2016). While these studies/surveys were conducted in the developed, Western contexts United States, Italy, and the UK, it is likely that the lack of confidence in providing IPV screening and care extends across geography and clinical circumstances, as IPV is always situated in complex contexts and requires careful attention from providers to the inherent sensitivity to the topic. The differing levels of confidence and training/education among providers lead to variability in IPV screenings and care across

clinicians, even within a single practice (Alvarez, Fedock, Grace, & Campbell, 2017). Provider confidence has implications for screening quality and consistency and invites an opportunity for quality improvement around care delivery regarding IPV screening and referrals.

Best Practices for Providers

Evidence suggests that in order for a clinical intervention around IPV to be effective it must be specific and relevant to the context of a woman's life (Rivas, Vigurs, Cameron, & Yeo, 2019). Thus, educational content should specifically include exercises and examples that highlight the unique circumstances of immigrants and people of marginalized racial and ethnic groups that providers may interface with regularly. Other key components to consider when conducting effective clinical interventions include: the severity and type of abuse, whether the client lives with the abuser, and the client's economic and legal dependencies (Garcia-Moreno et al., 2015). One study, a systematic review of 98 IPV advocacy intervention studies found that providers must understand that "women's safety was not necessarily at greatest risk from staying with the abuser" (Rivas et al., 2019, p. 2). This framework for approaching the patient acknowledges the inherent complexity of each survivor's situation, and allows the provider to provide support and resources that reflect each patient's unique needs. Additionally, evidence suggests that providers need to be a bridge to community resources, and a systems approach is the more effective to actually connecting patients to IPV care (Miller, McCaw, Humphreys, & Mitchell, 2015).

All women of reproductive age should be screened for IPV at each annual well-woman visit, and pregnant women screened at least once per trimester, and then again postpartum, regardless of perceived risk ("ACOG Committee opinion no. 554: reproductive and sexual coercion," 2013). Screenings should be guided by a comprehensive screening protocol that

includes a well-practiced script that avoids stigmatizing language such as “battered” or “abused,” and utilizes behavior-specific words such as “hit” or “yelled” (Breiding, Kathleen, Smith, Black, Mahendra, 2015). Screenings may take place face-to-face or on as part of written questionnaire. Various tools are used to conduct these screenings, such as the Women Abuse Screen Tool (WAST), the Composite Abuse Scale (CAS), Abuse Assessment Screen (AAS), the Intimate Partner Violence Among During Pregnancy Instrument (Doi, Fujiwara, & Isumi, 2019), among others. Regardless of the tool employed by a healthcare provider, the screening and all referral information should be given in a patient’s primary language, in a private setting, and with plentiful time for questions and conversation (Paterno & Draughon, 2016). In order to guarantee providers are delivering screenings in a high quality and consistent manner, training must be comprehensive and routine, as brief, stand-alone trainings have been shown to be ineffective to successfully prepare clinicians to provide meaningful services to IPV survivors (Zaher, Keogh, & Ratnapalan, 2014).

Conclusion

In sum, the research related to IPV prevention and treatment shows a clear opportunity for addressing health-related consequences of IPV survivors in the clinical space. However, clinical interventions for IPV are often poorly executed and supported and use outcome measures far outside the scope of impact of such interventions. Making a meaningful impact in the IPV landscape for women will require skilled, confident midwives conducting standardized, thorough screenings, and confidently making clear, helpful referrals, as part of a larger initiative to holistically support patients through their journeys through IPV.

This project responds to the literature by acknowledging the critical role medical providers play in supporting patients experiencing IPV during pregnancy and across the lifespan.

The limited literature about clinical interventions for IVP in Latin America, and Chile specifically, validate the project's needs assessment approach and iterative approach to the intervention. The literature demonstrating a need to robustly support providers, and specifically midwives, conducting IPV screenings support this project's overall goal to create an IPV manual, which includes process maps, training materials, and clinical best practices for providers, and prevention/education literature for patients, in a public clinic in Santiago. All project deliverables acknowledge the complex nature of IPV in patient's lives and their unique and shifting needs by framing project success on building trust and connectedness with providers, fighting stigma, improving provider confidence, and fostering thinking about patient autonomy and resilience, instead of focusing on a patient leaving one's abuser. All materials created in collaboration with Chilean clinical and cultural experts.

Chapter 3: IPV Manual For CESFAM Recoleta

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I. Manual Overview

This manual is the result of an inter-disciplinary, transnational collaboration of researchers, public health practitioners and midwives, funded by the Emory Global Health Institute. The objectives for the project were: The project objectives were to 1) Explore the experience of IPV survivors who declined a referral for services or did not access these services consistently, and 2) Explore the perspective of the midwives who provide referrals for IPV services on their perceptions of the non-use of IPV care. The purpose of the project that emerged out of this period of data collection is: to make clinic-specific, data-driven recommendations to clinic leadership at CESFAM Recoleta in Santiago, Chile, to improve the IPV referral competencies and processes of their midwives. The project aims to bolster CESFAM Recoleta's screening and referral consistency, efficiency, and efficacy by:

1. Mapping the current IPV screening and referral process used by clinic midwives and making targeted process improvement recommendations
2. Using the perspectives garnered in the formative research project from summer 2019 to inform the creation of training content for providers and outreach materials for patients

Data for the project were collected over a six-week time period in May and June of 2019 at CESFAM Recoleta by three Emory University student researchers in collaboration with University of Chile School of Medicine faculty midwife researchers, Dra. Lorena Binfa and Dra. Loreto Pantoja.

What follows is the primary deliverable from the project: a resource created explicitly for the use of leadership in CESFAM Recoleta, based entirely off the data provided by key informants, researcher observations, and available literature. Along with a comprehensive report of all the major findings from the project, included in the manual is a list of proposed

competencies for providers caring for patients with IPV, formal recommendations for improvement, and suggested resources to support any future implementation.

II. Methods

This project was originally designed as a qualitative study exploring the decision-making processes of CESFAM-Recoleta patients around pursuing IPV resources post-referral. However, due to unforeseen challenges in participant recruitment and the desires of clinicians interviewed, the scope of the project shifted to an informal needs-assessment approach, with the goal of delivering meaningful, clinic-specific recommendations to the clinic by the project's end around IPV care best practices and provider support around IPV care.

All interviews were conducted using a qualitative, semi-structured, in-depth interview approach. The interviews were conducted using interview guides developed by the Emory research team and reviewed by Dr. Lorena Binfa and Dr. Loreto Pantoja. Iterative review of the guides throughout the six weeks of data collection allowed the guides to grow with the project.

A total of ten key informant interviews were conducted with CESFAM-based midwives (5), social workers (1) and psychologists (1), as well as patients (3) who had received pre-natal care at the CESFAM and who had screened positive for IPV. All interviews were conducted in Spanish and were attended by at least one Emory student researcher. Most interviews also had a note-taker present from Emory's research team as well as a Chilean midwifery student or a member of the Chilean side of the research team, who served as a cultural broker during the interviews.

Key informants who were providers were recruited through recommendation and generous coordination from clinic-leadership, and patients were recruited through a convenience sample of patients who participated in a previous study on IPV, as well as through referral to the

project from clinic-based midwives. All participant recruitment, enrollment, and data collection were completed in accordance with Emory IRB and University of Chile IRB approvals.

Interview recordings were transcribed by American side of the research time, and also by a hired transcriber. No formal translation of the transcripts was conducted, as all relevant members of the analysis team were fluent in Spanish. All transcripts were de-identified for analysis. One American student researcher, upon return to the United States, analyzed the data informally for this project. Recurring topics were extensively memoed across the transcripts and compared across the key informant populations in order to develop key themes that emerged from the data.

III. Assessment Findings

Qualitative, key-informant interviews conducted with midwives, psychologists and social workers in the clinic, along with patients with IPV experience, highlighted some general themes around IPV care provision in the CESFAM. The findings from the interviews are organized by theme and elaborated on here.

Scope

Providers of all types at the CESFAM understand that there are innumerable factors influencing one's risk for IPV, and impacting one's decision-making around coping with and/or exiting an abusive partnership. In other words, when considering how best to support patients experiencing IPV, providers recognize that the scope of the problem is overwhelming in size. Many of the providers' recommendations about IPV prevention are around society-level interventions that would help shift cultural understandings of gender dynamics, expand the understanding of IPV to include abuse beyond physical violence, begin challenging the normalization of abuse in romantic partnerships, and improve the provision of services to more

adequately address the needs of women experiencing abuse. These providers' recommendations reflect the larger body of intervention literature around clinic-based IPV-prevention efforts, which broadly shows that screening and referring alone is inadequate to protect against repeat IPV-incidence. Despite this CESFAM's providers' immense skill sets, the numerous factors influencing the prevalence of IPV are too deeply embedded within social, cultural, and economic institutions to be meaningfully addressed only at the clinic level.

One factor related to the immensely broad scope of IPV that providers bring up repeatedly, is the nature and prevalence of social conditioning related to IPV, and the role of previous exposure to family violence. Providers emphasized that acceptance of violence is often informed by cultural and familial cues, such as the role of machismo culture on normalizing various gender-related behaviors, and the power of exposure to intra-familiar violence during one's childhood on one's tolerance of IPV. The providers' perceptions of the role of generational trauma regarding tolerability of IPV cannot be understated, and various providers stated that they observed IPV to have a cross-generational effect on their patients.

Patients also noted the profound effect of broader cultural and familiar socialization on the risk of violence. One patient stated that her abusive partner was, indeed, very machista, but qualified this statement by explaining that he experienced family-related trauma in childhood. Providers express their frustration at how limited their power is in addressing the breadth of influences impacting IPV prevalence, and note how, without efforts to curb violence and support women attempting to leave abusive partnerships at the public policy and community level through legislation and comprehensive resource provision, even a successful clinical intervention's efficacy would be stunted.

How Midwives Understand Their Role

Throughout the interviews, midwives were adamant that they have an important and unique role to play in helping patients experiencing IPV. While a midwife's job often requires her time and attention be directed toward biomedical activities and concerns, asking things beyond the biomedical perspective is also within the scope of her work.

The midwives felt like they offered a specific set of skills and strengths to their patients experiencing IPV, like being adept probing subtly for sensitive information, empathetic, perceptive, observant, trustworthy, capable of rapport building, and strong team members. Midwives across the board described themselves as strong listeners, which is critical to their role. While all midwives felt that screening patients and providing care for IPV was within the purview of their work, one midwife stated that she felt like she sensed that some patients would be more likely to share about their experience with violence with the social worker or psychologist than with a midwife. This provider also said she felt that the psychologist was the best-equipped person on the team to help a patient experiencing IPV, while other midwives expressed that they generally felt like they had the skills needed to provide assistance to patients experiencing IPV.

While most midwives say that their role in the IPV care provided at the CESFAM is to screen, gently probe, and then refer patients to other available resources, some midwives stated that they sometimes found themselves in other roles as well, such as being an impromptu advisor or social worker to a patient with questions about immigration or childcare or employment. One midwife said that the midwives in the clinic serve as a giant funnel that catches all the patients coming into the clinic and filters them down the path to care that they need to be on. In order to manage the pressure of these many roles that they find themselves in and the intense

emotionality of assisting patients with IPV, midwives said that their work sometimes feels very exhausting, and that staying resilient is crucial in order to continue providing high quality care.

How Clinicians' Goals Regarding IPV Care Provision

Clinicians interviewed had a united vision regarding their goals and perceived role in addressing IPV in their clinical practice. Overwhelmingly, providers desired to help their patients broaden their understanding of what acts constitute IPV. Providers stated that most of the IPV witnessed in the CESFAM is mild to moderate, and that, overall, they find many of their patients to have a very normalized perspective of violence. Thus, providers find that many of their patients who are experiencing verbal abuse or other controlling or coercive behaviors, do not consider themselves in abusive relationships. Providers universally believed that they have a role in helping to end the normalization of violence and held a desire to help their patients realize that verbal abuse, such as name calling, yelling, or controlling a person's access to finances is still abuse.

Challenges Identifying IPV

Providers expressed several critical challenges to identifying IPV experience with their patients. For example, the language barrier between the midwives and their Haitian patients who speak Creole make it difficult to built the requisite amount of trust required for an IPV disclosure. Midwives noted that even when a translator was being used during the appointment they were skeptical of the quality of the translation and that one's tone and sentiment would not be accurately relayed.

Because most of the IPV cases in the clinic are mild or moderate and characterized by verbal and emotional abuse, instead of physical violence, providers are often reliant on patients' disclosures of violence, as opposed to physical manifestations of abuse, such as a bruise. The

midwives emphasized that for most of their patients, violence is incredibly normalized, thus making it difficult for a woman to know that she is currently experiencing violence. If a woman does not believe that she is experiencing violence, then disclosure and help seeking becomes unlikely.

Some women, however, are aware that they are in a violent relationship. For these women, midwives say that shame and fear can be strong barriers to identifying her situation of IPV. One provider suggested that the role of shame was stronger in Chilean women than women of other nationalities, as Chile has made societal-level efforts to combat IPV rates. As such, women who are experiencing IPV, despite national efforts to condemn it, may be more prone to feeling shame about their situation. Midwives perceived that women who were fearful to disclose might fear retribution from a partner, or fear losing her children as a result of the disclosure.

Ways providers Witness IPV

Every provider interviewed for the project understood IPV according to the WHO's definition, which specifically acknowledges non-violent forms of abuse and coercion, and overall, providers in the clinic stated that most of the violence witnessed in the clinic was mild to moderate verbal or emotional abuse. Midwives, the social worker, and the psychologist, alike, described patients reporting abusive language, such as yelling and name-calling, in addition to some reports of physical violence. Patients corroborated the sentiment that most of the violence they experienced was psychological, often in the form of yelling and name-calling, as opposed to physical.

Providers also stated that they have seen IPV manifest as a male partner controlling an immigrant woman's ability to learn Spanish upon arrival in Chile from a non-Spanish speaking

country, with one provider saying "a muchos hombres no les gustan que sus mujeres aprendan el español porque eso también les da independencia a ellas." Some abusive partners insist on coming to appointments at the CESFAM and being their partner's translator, which can be a sign of control.

Providers stated that abusers found other ways of controlling their partners, such as employing financial control and monitoring where they are going. One provider stated that sometimes she sees young women come in for an appointment with a much older man, which often hints at a power imbalance in the relationship that makes the woman more vulnerable to abuse. Patients and providers alike stated that many men's desire to control their partners' actions and finances was a result of machismo culture. One patient stated that her abusive boyfriend would justify his strict financial control over her by saying that this is how it is done in his home country. Providers stated that they have encountered male partners engaging in controlling and coercive behaviors around the topic of family planning, such as hiding a woman's birth control pills or forcing his partner to have sex in order to force her into a pregnancy.

Both providers and patients confirmed that a partner's abusive behavior often changed during a pregnancy. One patient stated that her abusive partner's behavior improved when she was pregnant because growing and taking care of the baby gave her a clear place in the house. However, providers also stated that they had seen abuse increase during a pregnancy, with some abusers engaging in verbal and emotional abuse with accusations around the paternity of the child.

Providers also stated that they often see IPV co-occur with mental illness or substance abuse. One patient who lives with a mental illness said that her former partner used to call her

derogatory names related to her mental illness. She said “mi pareja me decía mucho 'loca'. Y que estaba loca, 'loca culiada' me decía.”

It is important to note that, because of how heavily socialized many people are into specific, often imbalanced, gender dynamics, patients experiencing violence may also exhibit controlling or abusive tendencies. For example, one patient who, after expressing frustration at her partner controlling her access to financial resources, expressed dismay at his poor job of controlling his sister’s sexual behavior. As such, providers sometimes witness their patients experiencing abuse detailing their own abusive actions or tendencies.

How Midwives Assess IPV

While midwives in the clinic administer the EPSA as a tool to identify IPV in their patients, not a single provider indicated that that was sufficient in order to adequately assess someone’s exposure to violence. As such, providers employ a wide variety of strategies during appointments in order to elicit the information they desire from a patient about possible IPV experience. These tools are used for the first time during a patient’s first appointment, which midwives state is a critical period for developing a patient’s trust and comfort. For example, providers talk at length about being careful to notice a patient’s mood during an appointment. They assess her facial expressions and body language, and then weigh that information against any previous experiences they have had with the patient to attempt to identify any changes in demeanor. Additionally, they look for physical manifestations of abuse and then note explanations for such bruises, such as claiming the bruise came from a fall.

Providers also try to keep a close eye on the patient’s chart to look for inconsistencies or signs of abuse. For example, one midwife brought up a patient who had been pregnant, but terminated the pregnancy, and then was pregnant again three months later with this same partner.

This situation seemed unique to the provider and inspired her to probe more for potential coercion or abuse in the partnership.

In addition to attempting to be highly thorough in their observations about the patient and how those observations might relate to IPV experience, midwives all emphasize the importance of asking patients the easy, clear questions in subtle ways. One midwife gives examples: "The ideal is to see it through conversation. For example, I ask her, "Are you with a partner? And your partner lives with you? How far along is the relationship with him? Do you have arguments sometimes?'…Do they say ugly things? And…they tell me, 'In reality we argue, we say things, but with respect." In addition to asking gentle questions, trying to tease the information out the patient, midwives also note that they ask patients about the amount of social support in their lives by asking if they have any other family in Chile, or close woman friends. The midwives attempt to do all of this during an appointment, despite feeling rushed for time.

Challenges to Addressing IPV During Midwife Appointment

Midwives noted some logistical challenges to addressing IPV during clinic visits. They expressed concerns about the level of bureaucracy in the clinic, with one midwife saying she often felt like a secretary due to the large number of papers to fill out during each appointment. Other providers detailed frustrations about clunky EHR systems, overbooked schedules, demanding levels of documentation required for each visit, and a growing sense of mechanization of care-delivery, all of which can affect one's effectiveness at building the necessary rapport and trust required to fully assess IPV and catalyze the appropriate response. Even though the first appointment is a lengthy hour long, providers say there is a lot to do in that hour and very little time to sit and discuss mental health or exposure to IPV.

Building Trust

All midwives spoke to the profound importance of building trust with their patients during appointments in order to increase the likelihood of IPV disclosure and uptake of any offered resources. When asked how they fostered building trust with their clients, midwives discussed how structural factors as well as interpersonal factors impacted their efforts.

Structural factors that support trust building between clinician and patient include having long enough appointments, especially during the first appointment, which is a critical time to build a bond with the patient, having clients see the same midwife each time, and having appropriate translation services available for patients who don't speak Spanish.

Another structural factor that impacts trust-building process during appointments is the EPSA tool used by midwives to screen for IPV. Midwives unanimously expressed that the EPSA is not competent at garnering the information needed to more deeply engage with a client around her experience with IPV, due to it's questions being overly superficial and broad. As such, midwives discussed interpersonal strategies they employ to foster trust and connectedness with clients, highlighting the importance of giving time and space to listen to the patient, being sensitive to her experience, not being prejudiced, and expressing empathy for the patient. Other strategies involved attempting to understand a patient's subjectivity and reinforcing a shared decision-making framework by centering a patient's autonomy when offering suggestions or referrals. One way midwives do this is by asking "te gustaria" in front of any suggestions, in order to emphasize the patient's control in the situation, and hopefully foster her trust and engagement in the process.

Instead of asking directly about IPV, some midwives talked about asking casually about a woman's life, her partnership, and how her partner felt about her pregnancy before potentially asking about what arguments were like, etc. Additionally, several midwives discussed the

importance of asking about the health of a client's partnership routinely throughout her pregnancy, and not just at the beginning.

Patients themselves also noted a desire to feel that they could trust their provider when considering IPV disclosure. When asked how providers can best foster that sense of trust, patients said that feeling like their provider would take the time to listen to and understand them without judging them, and finding their provider to be kind, were key.

Unique Needs of Immigrant Patients

Providers stated that most immigrants seen in this CESFAM were from Haiti, Bolivia, Peru, Venezuela, and Colombia. All providers interviewed were unanimous in expressing that the clinic's large immigrant population had unique needs with regard to IPV care provision.

Regarding prevalence, one provider noted a perception that IPV was more common in the clinic's immigrant population. However, another provider complicated that idea by suggesting it was easier to recognize violence in immigrant populations, as Chile has a more progressive conversation happening around IPV that made it harder for Chilean women experiencing IPV to disclose that to another Chilean woman, out of shame.

Machismo culture was stated to be a relevant factor for all women seeking services at the CESFAM, and an influence on a woman's willingness to pursue IPV-related services. Some providers perceived its influence to be stronger for immigrant women than Chilean women. Providers also made generalizations about the types of violence commonly found in various immigrant communities. For example, one midwife said that Haitian women are more likely to report forced sexual contact than women from other countries.

All providers explained that there were immense difficulties posed by the language barriers between Haitian patients and CESFAM providers. Even when translation assistance was

provided, some midwives expressed concern that what they were trying to communicate was not being translated in a way that adequately captured their tone or sentiment, and that having to work through a translator inherently stifled the connection between the patient and provider.

Providers, overall, associated immigrant status with more rigid understandings of gender roles and a higher likelihood of having a normalized view of IPV. All providers seemed to possess a sense of understanding around the structural challenges of being a low-income immigrant in Chile, citing fewer job opportunities, difficulties are immigration status/having the right papers, living in very crowded spaces, and possessing limited social network and support system. Because of their highly vulnerable position in Chile, providers say these immigrant women are also at an increased risk of abuse in realms outside their relationship as well, such as on the street or at work.

Project participants who were immigrant patients at the clinic confirmed many of the structural challenges of being an immigrant seeking care for IPV in Chile, with emphasis placed on severe financial barriers to accessing IPV care, general discrimination and intolerance felt from Chileans, and a lack of social support.

Patient Willingness to Accept Referral

Providers stated that even if a patient did feel comfortable disclosing her IPV experience during an appointment, it was not always a guarantee that they would accept a referral to a resource, either inside the clinic or at an external agency like the CdlM. According to the midwives, when offered a referral to the CESFAM's own psychologist and social worker, the patient generally accepts. However, regarding referrals to the CdlM, one provider's perspective is that, due to a wide variety of factors, referred patients do not go.

As mentioned above, having a trusting relationship, as well as a dynamic that emphasizes a patient's autonomy and decision-making power with one's midwife, is seen as critical to IPV disclosure and referral-uptake. In order to foster a patient's sense of autonomy, one midwife said she often tells her patients, "Voy a apuntarle la primera cita y si le gusta diga a la psicóloga que le gustó, y si no le gusta dígale que no le gustó y no sigues más."

Another midwife said that a patient's sense of empowerment and self-esteem are critical to help-seeking behavior. She stated that patients needed to "agarrar fuerza," through some mechanism, such as finishing one's studies, or having one's own small source of income, before being able to take large steps toward resource utilization and potentially leaving an abuser.

Provider Perceptions of Clinical IPV Detection Tools

Providers were very forthcoming with their criticisms of the IPV detection tools used in the clinic, such as the EPSA and the Edimburgo, with most of the feedback focused on the EPSA, as it pertains more specifically to IPV. Various providers stated that the EPSA was overly broad, and that it failed to ask clear, concise, specific, and time-bound questions about one's IPV experience. One provider stated that because the EPSA only asks if a patient has *ever* experienced an episode of IPV, and doesn't clarify how long ago that exposure was, it leads to a large number of false positives, as patients may have marked "yes" to indicate an abusive relationship long in the past.

Because administering the EPSA doesn't generally elicit the desired information during the screening outright, providers have learned to devise and implement their own screening processes, explained above under "How Midwives Assess IPV".

Providers expressed conflicting opinions about how to improve the tools used to screen patients for IPV. For example, many providers expressed a desire for a different, more specific

and comprehensive instrument, in order to facilitate the screening process. Several providers noted having had a positive experience with the WAST tool they had been exposed to in previous years. However, it was also noted that, with so much to do in the appointments, adding an additional tool would add pressure to an already busy appointment slot.

Provider Perceptions of Clinic-based IPV Care

Overall, providers' perceptions of the clinic's IPV care process are incredibly favorable. Providers appear to be deeply trusting of the resources provided by the clinic, especially those provided by the psychologist and social worker. All midwives felt comfortable referring their patients to the clinic's psychologist/social worker team, and expressed an appreciation for their work and willingness to see patients in need on short notice, despite understanding that those resources are already stretched very thin. Unanimously, midwives felt that this team of three different types of providers form a network of support that is ready to meet a wide variety of patient needs.

One concept that came up repeatedly in interviews was the fluidity of the referral process to in-clinic IPV resources. While most patients are referred to the clinic's resources in a procedural manner, multiple providers stated that this triad of providers was open to "breaking all the rules" in order to get patients in critical need of additional resources access to those as fast as possible. This could look like a midwife physically seeking out the psychologist or social worker in the clinic, or contacting one of those additional providers via Whatsapp, to inquire if they could see a patient immediately. Overall, all three types of providers seemed grateful for this teamwork aspect of service provision, and the large amount of trust between providers.

Interestingly, amongst the midwives exclusively, a few concerns were raised about the quality of IPV care delivered to patients across providers. To make up for the EPSA's

shortcomings, providers are employing their own screening strategies for patients. As such, some providers are that variability in provider confidence, comfort, and ability with these informal screenings means some patients are receiving poorer quality care than others who have providers with more training and confidence with IPV-related discussions.

Another important aspect of the clinic-based IPV care was the weekly talleres. These talleres are for patients who had been referred to additional IPV services in the CESFAM by their midwife, and are used to filter patients to the most applicable resource based on her experience and needs. From the provider perspective, these talleres are critical to ensuring that the patients most are able to access the clinic's limited resources. However, one patient who was made to go through the taller process before accessing an appointment with the psychologist said it felt like a barrier to care.

When asked about the monthly meetings that take place, where providers share complex cases of abuse with other providers in the CESFAM, every provider expressed favorable opinions about them and their utility. One midwife said, "Entonces como que en equipo hay muchas mas ideas de poder abordar a la paciente, o me dicen, 'mira, yo ya la vi y le indiqué esto, y le dije esto'. Entonces es super bueno." These meetings help providers feel supported as they care for patients experiencing complex cases of abuse, and create a team environment that feels reassuring to providers.

Perceptions of External IPV Resources

While providers unanimously express appreciation and approval of the in-clinic IPV resources offered to patients, they were less confident in the services provided by external organizations, such as the CdlM, which aids women specifically in the circumstance of IPV, and COSAM, which provides services for people experiencing mental illness.

With regard to what the CdlM could offer to their patients, providers stated that its strength is in providing legal counsel to women seeking to leave their partners, as they have lawyers on staff to answer questions about the legal implications of leaving an abuser, such as what rights one has if one's abuser is also the father of one's children. The offering of legal counsel is one critical distinction between the CdlM and the services offered by the CESFAM. One provider said that there is some overlap in services provided by the CESFAM and the CdlM, as they both house psychologists and social workers, which can lead to redundant service provision. And, since the women referred to these resources from the CESFAM are often familiar with in-clinic psychologist and social worker, providers felt that for general psychological support, providing support inside the CESFAM, a known and trusted space, would be a better, more comfortable option for patients.

Despite a potential redundancy of service provision between the CESFAM and the CdlM, one provider stated that the CdlM's work could nicely complement the CESFAM's work. However, multiple providers stated that there has been some confusion regarding the appropriate order of operations for referring a patient to the CdlM. For example, one provider said this about the process: "Mandarla a la casa de la mujer, la casa de la mujer tiene que hacer el tramite en el tribunal, el tribunal tiene que ordenar un cupo, y ahí la van a recibir recién…. si no hay denuncia no la van a recibir." However, not all providers seemed so confident in their understanding of the process. One provider stated that she had thought that she could refer a patient who hoped to make a denuncia to the CdlM for help filing it with the police, but that the CdlM informed the patient upon arrival that she needed to come having already made the denuncia. Another provider stated that she's had patients who were afraid that going to the CdlM would make her feel pressured to file a denuncia in order to receive services. Overall, it is clear that referring a

patient to the CdlM is not a simple one size fits all solution. Rather, it is one step that sparks a complex series of steps that can be very confusing or difficult for patients.

Providers were uniform in their statements that, because of the complexity of the process, accessing care at the CdlM can be cumbersome for some patients. The CdlM and COSAM are also considered to be very overcrowded, and providers felt that the CdlM was inconsistent at following up with patients who had been referred by mail or email. Due to the center's crowdedness, one provider indicated that she had to be highly selective in referring patients there. She stated that she tried to dig to the bottom of a patient's situation in order to determine if she needed help immediately, or if she would be safe on her own for a while. Another provider confirmed that she also only sent very grave cases to the CdlM, and two providers stated that they had never referred a patient to the CdlM because of a perceived lack of utility for these patients' situations.

A patient who had recently been referred, but was unable to afford the metro ticket to their office, confirmed the presence of barriers to accessing care at the CdlM. When asked if the CdlM offered reimbursements for metro fare or had free metro cards available, she said no. When asked if she could access their resources remotely, such as over the phone, she said that one needs to present at the center in person to be taken seriously. Despite the barriers to access, this patient, who had utilized services at the CdlM in the past, said that she had a truly positive experience, stating "por lo menos le den un aliento o algo, una luz de esperanza por lo menos," and "te abren las puertas con los brazos abiertos". This patient had also received a referral to COSAM, but her perception of their mission and services were very different, saying that COSAM was primarily for people with developmental delays (un retraso).

One patient, who was presumably referred to the CdlM, says she never received a call back from, and thus never pursued that referral. A midwife who had referred a patient said that she could remember a time when she sent a referral over, but that her patient was never contacted by the CdlM, and thus the midwife herself had to follow-up on the referral. Some providers indicated that the CdlM often does a poor job, or very slow job, of following up with referred patients. As such, it appears that the referral and communication processes between the CESFAM, the patient, and the CdlM is riddled with gaps.

Snapshot of the Patient Experience

The patients who participated in the project reported having exclusively positive experiences receiving IPV-related care from the CESFAM. The act of talking with a trusted provider about an experience with IPV was, in and of itself, a worthwhile experience for the patient. One patient said, "Pues es que una igual lleva el peso, como el dolor, el peso, y que alguien lo escuche y que alguien lo entiende, que lo entienda a uno, ya es como algo mas diferente. Es que habla, hablar un problema con alguien es como una salida." Another patient, who was asked how her appointment went recently with the psychologist said, "Hoy me atendió muy bien, me ayudó mucho, me escuchó, que fue lo importante." This feedback substantiates the providers' perspectives that their in-clinic IPV-care quality is high.

Patients also provided some feedback on areas of frustration or concern. For example, one patient, who had utilized the psychologist's services at a different CESFAM in the past for IPV-related concerns, and thus knew she desired the support of this clinic's psychologist for similar issues, found that she was asked to attend one of the weekly talleres before being allowed to make an appointment. She found this extra step to be cumbersome and unnecessary for her situation. One patient, who had received services from the psychologist, said that, while the

psychologist was indeed helpful, she also needed of an appointment with a psychiatrist for assistance managing her mental illness. When asked if she would be able to make an appointment with the psychiatrist in the CESFAM, the patient said that she did not know the process for doing so, and had been told it was very complicated, suggesting that utilizing services outside the midwife/psychologist/social worker team was less accessible.

A Call for a New Treatment Framework

Throughout the interviews, a thread emerged around providers' and patients' desires for a new clinical approach and priority around IPV care provision in the CESFAM. According to one of the providers interviewed, the current approach focuses heavily on attempting to connect patients to external resources that emphasize taking legal steps to leave their abuser, through the process of filing a denuncia. However, this provider stated that the structures of support for women who do so are not well equipped to help carry her through the entire process of leaving an abuser, beyond filing the original denuncia. She shared story of a patient who had been referred by the CESFAM to the CdlM. The CdlM then instructed her on filing a denuncia, but doing so made her partner throw her out of the house, leaving her even more vulnerable and with fewer options than before, as there was no process in place to provide her with safe, reliable housing after the filing of the denuncia. The provider said, "…hay todo un aparataje supuestamente, o un dispositivo para que tu hagas la denuncia. Pero cuando tu haces la denuncia, quien se hace cargo? ¿Quien te ayuda? ¿Quien te protege? ¿Quien te resuelve? ¿Quien? ... lo que hacemos es decirle, 'haz la denuncia a--interviene, hazte cargo, pero no como país, como institucionalidad, no les damos las herramientas para que ellas puedan salir." For example, she said that Chile lacks a sufficient number of shelters for women fleeing violence.

Beyond the system's lack of preparedness to support women after filing a denuncia, one provider stated that the denuncia itself does not serve to protect women from additional abuse or harm from a partner, stating that her understanding was that the vast majority of femicide cases in Chile had a denuncia.

The denuncia not only lacks utility for many women experiencing abuse, but it also is often unwanted. One patient interviewed for the project said that, while she was indeed experiencing verbal abuse and controlling behaviors from her partner at home, she planned on staying with him because she wanted her son to have a father. The providers said that the vast majority of patients do not desire to take a judicial approach to their situation at the time of service, confirming a sentiment supported by volumes of data, which suggest that women often do not want to leave their partners, but rather want the abuse to stop. One patient expressed interest in community-based resources, such as libraries in her neighborhood where she could spend time with her baby during the day for free, or events that would allow her to meet other young mothers in her neighborhood.

Providers articulated a variety of goals for patient-centered IPV care provision in their practices that stood out as having the potential to become a broader framework for use by other providers in the CESFAM. Examples include prioritizing helping the patient question the violence she is experiencing, showing a patient that another way of being a couple is possible, and helping patients make small adjustments in their relationship to help nudge the dynamic of their relationship into a more horizontal one, rather than a predominantly vertical one. These approaches challenge the approach that attempts to send patients down a path of adjudication, and rather keeps her close to the CESFAM, with providers that she trusts, receiving care that meets her where she currently is. The psychologist said that, over time, she has found that

patients experiencing abuse are often receptive to small pushes in thinking around broadening their definition of violence and finding minute ways to begin exercising small amounts of control in their relationships, in order to begin tipping the balance of power a bit.

Overwhelmingly, providers desire to address the profound normalization of violence that they see in their patient population. They desire that their patients adopt a broad understanding of violence that includes verbal abuse and controlling behaviors. Providers in this CESFAM have the power to address these issues with patients while maintaining a tone that supports patients where they are at in their journeys. This new, more unified, approach that prioritizes patient-centered, community-driven care over case adjudication requires a CESFAM-wide change in tone that would require training of the midwives, social workers, and psychologists. Thankfully, midwives stated that they would be open to more clinic-based trainings around providing stronger IPV care to patients.

IV. Proposed Clinic IPV Care Competencies

IPV Care Competencies

For CESFAM-Recoleta IPV Care Team

Build Trust with Patients

Help patients feel safe to disclose abuse

Question One's Biases

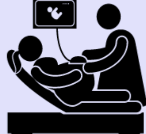
Consider and understand one's own role in violent systems

Conduct IPV Screenings

Confidently screen at appropriate intervals

Collaborate Across IPV Care Team

Utilize intra-CESFAM care experts



Provide Patient-Centered Care

Respect patients' needs and desires for care and intervention

Promote Healthy Relationships

Facilitate dialogue on horizontal power between partners

V. Recommendations for Quality Improvement:

The recommendations listed were developed by compiling recommendations made by patients and providers during project interviews, as well as from the literature around improving IPV service delivery in a clinic setting. All suggestions have been organized into Provider Training and Approach-based, Clinic-Based, and Community-Based recommendation categories.

Approach & Provider Training Recommendations:

1. CESFAM leaders implement a new paradigm for IPV-care provision among the IPV care team (midwives, social workers, and psychologists) that unifies that clinic's mission regarding the IPV care approach.
    - This approach is recommended to prioritize three aspects of clinical care for patients with IPV: 1. Utilizing in-clinic resources offered 2. Meeting patients where they are in their journey (i.e. Offering what is desired by the patient, and not what is necessarily part of the referral strategy) and 3. Normalizing non-physical forms of abuse and promoting horizontal power dynamics among intimate partners
2. Consider implementing a new, more comprehensive and specific IPV screening tool
    - See Appendix A for screening tool options that show promise for this context in that they are easy to administer and score, and have high sensitivities and specificities have been successful in similar contexts
    - Consider screening for abuse in other realms of a patient's life, such as at work, childhood trauma, or PTSD due to large population of highly vulnerable immigrant patients in the clinic.

3. Facilitate yearly or twice yearly IPV-related trainings to the IPV care team that promote the IPV care competencies outlined above as well as target the following topic areas training materials, including templates for pre- and post-training surveys for providers, and a Spanish-language version of the Social-Ecological Model are included in Appendix B.
    - Midwives and providers protecting their energy in their IPV-related work
        i. Helping patients experiencing IPV is "agotador". Resilience and self-care are key to prevent burnout and psychological distress
    - How to handle complex VIF cases where violence is highly normalized by focusing on helping the patient feel safe and confident discussing IPV with her provider, planting seeds around expanding the definition of violence and help-seeking in the patient
    - Prioritizing referring patients to community-based resources that foster connectedness, social support, and patient autonomy (ie. Local libraries, parks, women's centers, etc.)
        i. Consider creating a local resource list with the destination's name, addresses, hours of operation, phone number, and available services to give to patients
        ii. This resource may or may not mention IPV-related resources, and should be marketed as a community resource for all women, to protect the safety and privacy of patients who receive it
    - Conducting warm hand-offs to in-clinic IPV support teams

i. One provider thinks patients are more likely to follow through on a referral if their midwife contextualizes the referrals (explains how it works, what they should expect at their appointment with this other provider, that the psychologist is not only for people experiencing mental illness, etc.)

- Following up with patients after they have been referred to either in-clinic or external IPV resources
- Emphasizing enhanced consideration of when to refer a patient to the CdlM (what would be the criteria for this?); promote in-clinic referral and to community-support resources

4. Mindfully implement bias and cultural training and information into the IPV-team trainings
   - Integrate people from the patient/target population into leadership/training/care provision roles in the clinic, as providers expressed a desire to have a better understanding of the cultures and experiences of the immigrant populations they work with, in order to provide more specific care.
5. Create a training protocol for new hires on the clinic's IPV care approach and process

Clinic-Based Recommendations:

1. Improve quantity and visibility of uplifting messages that expand the definition of IPV and normalize IPV disclosure and help-seeking behavior
   - Engage local students and artists to create this content
2. Schedule several longer appointment slots per week that are protected for high-needs patients

- Providers suggest that some patients with more complicated cases may benefit from having more time to discuss and build trust around IPV

3. Provide education and support opportunities for patients in the clinic
    - Consider a weekly, biweekly, or monthly support group-style gathering. Support groups have the potential to catalyze processing around one's experience and understanding of IPV, which, when appropriately guided, can help address the normalization of violence that providers say is so common
    - An abundance of resources exist to help create and facilitate ongoing support groups for survivors. These resources include numerous activities to foster dialogue and reflection in participants.
        i. The Power and Control Wheel, along with its corresponding written activity, is a common resource for starting conversation around IPV and understanding its ties to various social and cultural institutions. It is attached in Appendix C.
        ii. The Family Violence Fund, out of the USA, has a Spanish-language manual for Latinx organizers and activists around IPV care provision with resources and activity ideas, all in Spanish. It can be found at:

https://www.futureswithoutviolence.org/userfiles/file/ImmigrantWomen/BreakSilenceManualSpanish.pdf

4. Examine the use of weekly talleres as a mandatory step for patients seeking care from in-clinic resources
    - Consider utility of talleres for patients who express a clear readiness for assistance from the psychologist and social worker, a such as the patient who asked, on her

own, for an appointment with the psychologist, who found the taller to be “una etapa extra”

- Incorporate training around referral-protocols to talleres for providers to accommodate any changes

5. Continue making every effort to help patients see the same provider for every visit
   - Midwives insist this is vital to rapport- and trust-building, as well as for overall IPV detection, as it allows midwives to notice trends in mood and behavior over time.
6. Promote community-resources to patients
   - Utilization of community resources can help foster social support, connectedness, and patient autonomy (i.e. local libraries, parks, women’s centers, etc.)
   - Build partnerships with local resources and advertise these resources in waiting areas and women’s restrooms

Community-Based Recommendations:

1. Scale up CESFAM-wide IPV care meetings to other CESFAMs, as well as to other healthcare bodies that provide primary care and screen for IPV, possibly including the Estaciones Medicas de Barrios across Santiago
   - These care meetings have wide support across the CESFAM, improve providers’ sense of support and competency, and likely improve care delivery to patients with complex cases of IPV
2. Promote and engage in community-wide anti-violence campaigns

- Providers and patients alike desire greater awareness campaigns about IPV across Chile, outside of the clinic space, in order to fight the normalization of IPV and help normalize help-seeking

3. Assist in the elimination of barriers to care
    - Consider providing free transportation to the CdlM for women experiencing severe abuse who need immediate attention at the Centro
    - Promote the development of additional shelters for women in need of a safe place to land after leaving an abusive partner

Appendix A
Screening Tools for Consideration

Tool 1: HITS: Hurt, Insult, Threat, Scream Screening Tool; Score higher than 10 is a positive screen

- Strengths: Captures severity; Emphasizes non-violent forms of abuse; Could easily integrate into the midwives' current practice of asking gentle questions; To avoid the scoring aspect, this screening can be adapted to be a series of Y/N answers to be delivered verbally
- Weaknesses: May be hard for patients to self administer; harder to score

HITS Instrument

Over the last 12 months, how often did your partner:	Never 1	Rarely 2	Sometimes 3	Fairly Often 4	Frequently 5
Physically **HURT** you					
INSULT you or talk down to you					
THREATEN you with physical harm					
SCREAM or curse at you					
				Total Score:	

Tool 2: Partner Violence Screen; Any affirmative answer given indicates a positive screen

- Strengths: First question is not specific to violence from an intimate partner, so could double as screening for violence enacting by others as well; The third question is unique to this screening and captures stalking/continued abuse from an old partner, which is important because violence can continue beyond a breakup; Simple to score
- Weaknesses: The second question is vague and doesn't capture tension/verbal/psychological/economic abuse, which are important aspects of the experience of the patients in this clinic's population

Item 1: Have you been hit, kicked, punched, or otherwise hurt by someone within the past year? If so, by whom?
Item 2: Do you feel safe in your current relationship?
Item 3: Is there a partner from a previous relationship who is making you feel unsafe now?

Tool 3: SAFE-T Questionnaire; Any affirmative answer indicates a positive screen

- Strengths: Asking indirect questions aligns with the current screening approach of CESFAM midwives; Easy to use and brief; Can be adapted to be verbally administered
- Weaknesses: Does not screen for sexual or physical abuse, but can provide a starting place for further probing into sexual/physical violence

Item 1: I feel comfortable/secure in my home/apartment
Item 2: My husband/partner accepts me just the way I am
Item 3: My family likes my husband/partner
Item 4: My husband/partner has an even/calm disposition
Item 5: If my husband/partner and I disagree, we resolve our differences by talking it out

Tool 4: Woman Abuse Screening Tool (WAST) Short Form; Any answer of "a lot of tension" and "great difficulty indicates a positive screen

- Strengths: Many midwives in the clinic are already familiar with the WAST from a previous study; Simple to administer verbally
- Weaknesses: Does not screen for sexual/physical/emotional/economic abuse, but can provide a starting place for further probing into sexual/physical violence

Item 1: In general, how would you describe your relationship?

A. No tension
B. Some tension
C. Lots of tension

Item 2: Do you and your partner work out arguments with…

A. No difficulty
B. Some difficulty
C. Lots of difficulty

Appendix B
Materials for Training Providers on IPV

Figure 1: Pre-Training Evaluation Survey Template (Sullivan, 2014)

Note: This template is currently worded for a train-the-trainers style event, such as training clinic leaders in how to train their reports on IPV care provision in the clinic. This can be modified for events that target all IPV care providers.

Train the Trainer Pre Evaluation Survey
TEMPLATE

Section 1

Testing knowledge before a training is optional and depends on the type of training being provided. If you want to increase knowledge about a particular topic (e.g., HIV/AIDS, reproductive coercion) you might want to include some items testing people's knowledge at the beginning of the training. This has two functions:
1) you find out what people already know, so you don't waste time reviewing information unnecessarily
2) you can see if your training actually did increase knowledge

It is helpful to us to understand the level of knowledge people have coming into this training. Please complete the following survey, answering to the best of your ability. Your knowledge (or lack thereof!) is not a reflection on your intelligence, it simply helps us understand what content to focus on in the training and what we can spend less or no time on. So please answer honestly. If you do not know the answer to a question please answer "don't know."

[insert your questions here]

Section 2

Train the Trainers generally have two functions. One is to increase people's ability to train on a topic (questions below). The other may be to increase the knowledge of participants about a particular topic (questions above).

These questions have to do with how prepared you feel to train others on this topic.

Right now:	Not at all	Slightly	Moderately	Very
1. How confident are you that you have the information needed to train others on ....*[topic]*?	1	2	3	4
2. How comfortable would you be in training others about....*[topic]*?	1	2	3	4

Figure 2: Post-Training Evaluation Survey Template (Sullivan, 2014)

Thank you for attending this training event. Please take a moment to complete this brief survey to help us improve upon future trainings. Your responses on this survey are anonymous.

Your first questions can measure the extent to which your training increased people's knowledge about a topic (if that was a goal), and the extent to which they know feel like they have the skills and confidence needed to train on the topic.

To what extent, if at all, did this workshop **increase your knowledge** about:	Not At All	A Little	Somewhat	A Great Deal
7. *[insert your specific item here]*?	0	1	2	3
8. *[insert your specific item here]*?	0	1	2	3
9. *[insert your specific item here]*?	0	1	2	3
10. *[insert your specific item here]*?	0	1	2	3
11. *[insert your specific item here]*?	0	1	2	3
12. *[insert your specific item here]*?	0	1	2	3
13. *[insert your specific item here]*?	0	1	2	3
14. *[insert your specific item here]*?	0	1	2	3
To what extent, if at all, did this workshop **increase your ability** to:	Not At All	A Little	Somewhat	A Great Deal
15. *[insert your specific item here]*?	0	1	2	3
16. *[insert your specific item here]*?	0	1	2	3
17. *[insert your specific item here]*?				

COMMENTS: ____
____

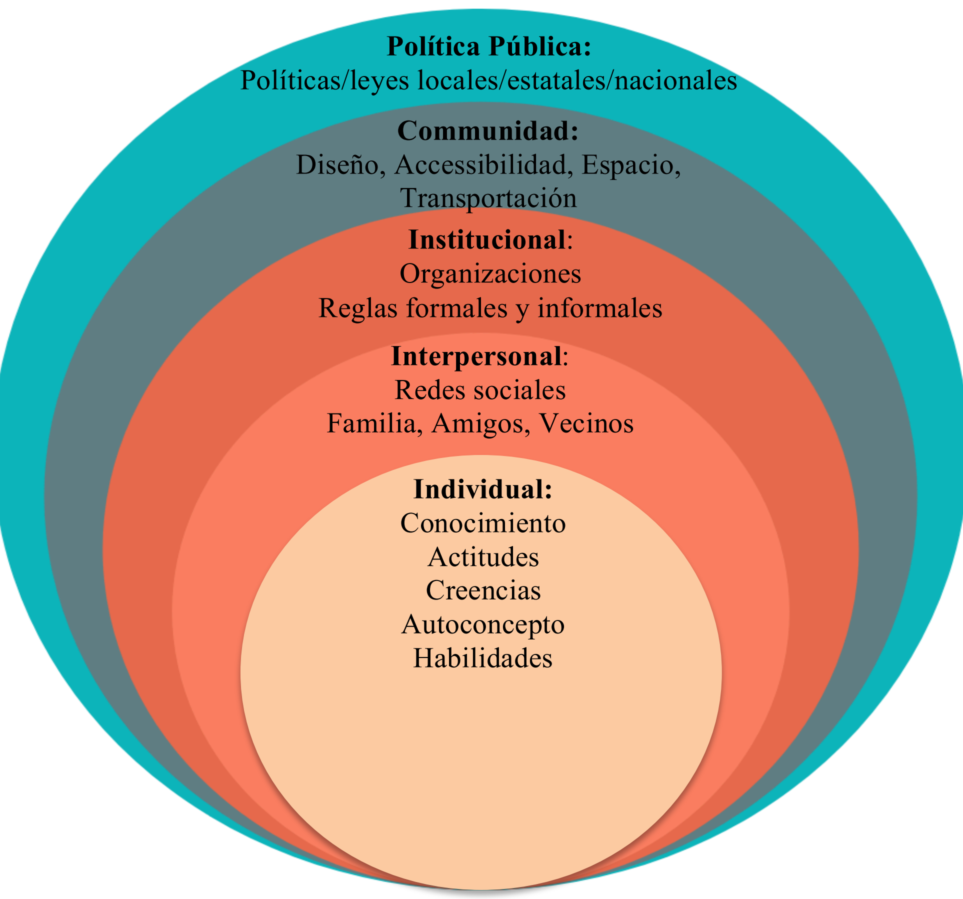
Please circle the response that best describes the overall quality and delivery of the training.

22. Was the information at the training presented clearly?	No	Somewhat	Yes
23. Was there enough time provided for each section of the training curriculum?	No	Somewhat	Yes

COMMENTS: ____
____
____

Figure 3: Social-Ecological Model for Provider Training

Note: Despite clinical providers' immense skill set, the innumerable factors influencing the prevalence of IPV are deeply embedded within social, cultural, and economic institutions to be meaningfully addressed at one level alone. The social-ecological model can be used to reinforce this point to providers, as well as to help them see how critical their work is to at the institutional level, and to think about how their work affects what is done at other levels.



Appendix C
Support Group Resources

Figure 4: The Power and Control Wheel

Figure 5: Power and Control Wheel Corresponding Exercise

Apoyos Institucionales y Culturales para Violencia Intrafamiliar		
Tácticas para poder y control	Decisiones institucionales y de la comunidad que apoyan a la habilidad de un abusador usar tácticas abusivas (policía, tribunales, medios de comunicación, clero, negocio, educación, servicios humanos)	Valores culturales y creencias que apoyan a abusadores
Abuso físico		
Abuso sexual		
Isolación		
Abuso emocional		
Abuso económico		
El minimizando y negando		
Utilizando niños		
Amenazas		
Utilizando el privilegio masculino		
Intimidación		

Discussion, Recommendations, and Conclusion

Discussion of the Product

This special studies project (SSP) produced an IPV care support manual for the Emory Global Health Institute Chilean research collaborators, Dr. Loreto Pantoja, Dr. Lorena Binfa, and the leadership team at CESFAM – Recoleta. The manual's results are the product of an informal analysis conducted by the SSP's author by reading and memoing the interview transcripts and pulling out key themes from the study's participants. Detailed descriptions of each of the themes are included for review by the clinic's leadership, staff, and patient community. Overall, the interviews illuminated a desire from the clinic's patients and providers for a reconceptualization of the clinic's approach to IPV care, as well as key areas for the improvement of service delivery. A set of recommendations emerged from the themes extracted from the interviews and are organized into three sections: Approach and Provider Training Recommendations, Clinic-Based Recommendations, and Community-Based Recommendations.

The Approach and Provider Training recommendation section emphasizes a transition to a new paradigm around IPV care provision in the CESFAM. Currently, providers report confusion around the role of the CdlM, such as how and when to use it. There is also variability in its utilization across providers, distrust in its reliability, and concern around its utility for patients, given the perception that its strength lies in providing legal support to help women leave their abuser. Shifting toward a clinical paradigm of care that utilizes community support and supports women where they are at in their relationships, as opposed to pushing women to take legal action, is affirmed by the literature and the interviews conducted for the project. In order to accommodate this shift in the clinic's goal and tone around IPV, this section provides detailed

recommendations for training providers in high-quality, patient-centered care that utilizes the clinic's many existing strengths as the foundation for IPV-related care provision.

Clinic-based recommendations in the manual revolve around making structural changes at the clinic-level in order to improve the quality of IPV care, meet the needs of patients, expand the clinic's messaging around promoting horizontal power dynamics in relationships, and providing spaces for patients to process their IPV experience. These recommendations include specific suggestions made by current providers in the clinic for quality improvement, such as creating a number of longer appointment slots each week for patients experiencing complex or more serious forms of abuse, and who may benefit from having a longer period of time to build trust and discuss the situation with her provider. Additionally, a recommendation is made to reevaluate the role of the weekly talleres, which one patient stated currently serve as an additional barrier to accessing psychological care in the clinic. The author understands that the talleres serve as a screening measure to ensure that patients are being appropriately referred to the clinic's limited resources. However, appropriately training providers to refer to in-clinic resources can eliminate the need for this additional screening, and the introduction of in-clinic support groups for patients experiencing IPV could reduce the demand for appointments with the clinic's psychologist.

Finally, community-based recommendations are included, which highlight the critical role that institutions outside the CESFAM play in impacting the nature and prevalence of IPV in a community. These recommendations stem from calls from providers and patients alike for stronger messaging and awareness campaigns at the community-level fighting the normalization of violence, especially non-physical types of violence, such as verbal abuse and various controlling behaviors. Additionally, a recommendation is made to scale up the monthly provider

meetings, where a team of providers across the CESFAM meets to discuss and brainstorm ideas on complex IPV cases in the clinic, and support each other in providing care to these patients, to other CESFAMs. These meetings are universally beloved by the staff and, as it was mentioned by one provider that these meetings are unique to this CESFAM, other medical institutions that are tackling challenges around IPV in a similar population deserve to know about this important care and support strategy.

Many recommendations, where feasible and appropriate, include resource suggestions in an attached appendix. The author hopes these will be helpful in the consideration and the implementation of the various recommendations.

Recommendations For Use

As has been thoroughly elucidated by various publications on IPV, as well as the interviews for this project, referring patients to resources with a goal of encouraging the survivor to leave the abuser and use state enforcement measures, such as filing a denuncia to do it, may not always be in the patient's best interest (Price, 2012; Rivas et al., 2019). Many of the patients experiencing IPV in this CESFAM are highly vulnerable immigrants, many of whom do not speak Spanish, are away from their families and systems of support, and face insecurity around not having appropriate state documentation. Not only are the police and courts a possible threat to many of these individual's existence in Chile, but heavily emphasizing the use of state-sanctioned mechanisms for formally naming an abuser fails to acknowledge the tremendous cultural and institutional supports for IPV that exist (Price, 2012). Thus, reframing the referral priorities of the clinic to utilize in-clinic resources as the first line of defense, and reserving out of clinic resources, such as the CdlM for cases in which the patient is expressing a clear desire to move forward with formal adjudication measures to leave a partnership, can serve to protect

patients. This concept is foundational to a radical approach to IPV that situates abuse between partners not only in the private sphere, but also intrinsically linked to and informed by institutions in the public sphere.

A New Screening Tool

The author recommends the adoption of a new, more specific and targeted IPV screening tool among the CESFAM midwives. While the Chile Crece Contigo program may mandate the use of the EPSA during maternity visits, the author argues that training on and implementation of a stronger tool will have benefits for both providers and patients. Specifically, clinic leadership should emphasize that the appropriate application of the new tool may help address the presence of providers' implicit biases that providers that may currently be hindering the efficacy of their own personalized screening processes and the care pathways they catalyze as a result. In this CESFAM's case, these biases may affect one's perceptions of the needs and experiences of women of other races, nationalities, and experiences. CESFAM leadership is also encouraged to consider how a new screening tool could open up opportunities to screen for abuse in other areas of a patient's life, such as at work, school, or on the street, which has been found to have similar health impacts on an individual (Gale, Mordukhovich, Newlan, & McNeely, 2019).

Four possible new tools have been proposed in Appendix A of the manual. They were selected due to their ease of use, reported sensitivities and specificities (Rabin, Jennings, Campbell, & Bair-Merritt, 2009), and the author's perception of their applicability to the clinical conditions present in CESFAM-Recoleta. Strengths and limitations of each are provided for each screening tool. Clinic leadership is advised to consider each tool, and any other tools they may deem fit, in order to select an appropriate tool to supplement the EPSA. Subsequent provider

training will be necessary before new tool may be implemented.

Training Providers

When conducting provider trainings on IPV screening and care provision, clinic leaders should prioritize minimizing uncertainty aversion in patients by emphasizing confidentiality during visits, streamlining IPV referral and care processes in order to reduce decision fatigue amongst providers, and minimize the cognitive burden placed on patients during visits, as suggested by the authors of the publication "Applying Behavioral Insights to Intimate Partner Violence: Improving Services for Survivors in Latin America and the Caribbean," (Garnelo, Bustin, Duryea, Morrison, 2019). This paper provides a behavioral science lens to the development of IPV support strategies. It provides a diagnosis of barriers to IPV care delivery and access, as well as intervention ideas, informed by behavioral science literature, which can serve as a starting place for clinics hoping to improve their approach to patients experiencing IPV.

Additionally, efforts should be made during trainings to tie the normalization of IPV to the normalization of other socially sanctioned forms of abuse, such as the normalization of obstetric violence. While providers themselves are highly aware of the profound power of the normalization of violence in the communities they serve, this attention to and awareness of how normalization of violence aids its prevalence must also be turned inward to ensure that providers are reflecting on their own norms and care processes that could potentially be enacting violence on others, or contributing to its presence in society.

The project's author also formally recommends that this CESFAM continue its leadership stance around IPV by fostering and promoting broader dialogue around IPV in the surrounding community, per the sentiments expressed by providers and patients alike during project

interviews. However, all parties involved in the project are cognizant of the profound financial constraints placed on this CESFAM and the limitations those put on the clinic's ability to engage the broader community in IPV-prevention efforts and messaging. While the Health Resources and Services Administration (HRSA) of the United States has a plan of action for awareness raising for clinics that involves conducting trainings for providers, conducting training events in the community, and reaching out to local media to publish letters to the editor and obtain free printing services for posters for health centers that clinics in Santiago could modify and adopt, this CESFAM is encouraged to develop its own community-engagement strategies that suit its budget, human resource capacity, and goals.

Patient Support Groups

Holding support groups for women who are experiencing, or who have survived, IPV has been found to decrease experiences of depression and improve self-esteem in participants (Santos, Matos, & Machado, 2016). To be trusted, usable events, they should be held at regular intervals, in a recurring space, and at a time that is mindful to the needs and duties of those in the target population. Clinic leadership may also consider allocating funds to provide refreshments and the appropriate materials for the exercises (such as a white board or large paper, and markers) in order to improve the quality of the support groups. Care should be taken to ensure that the intent of the group, as a support resource for women experiencing IPV, is adequately protected, to ensure that patients feel safe attending. Additionally, the clinic leadership will need to make a careful choice in its selection of a provider to run the groups, as they should be familiar with the Freirian method of community engagement, a strong listener, and skilled at managing/facilitating a dialogue around a complex, highly sensitive topic.

Power and Control Wheel

The Power and Control Wheel (PCW), developed by the Duluth Model, an IPV advocacy and intervention organization out of Duluth, MN, centers conversations around IPV within both the public and private spheres, and is an powerful tool to help people experiencing violence name and better understand their experience with violence. Appropriate application of this tool ensures that violence is contextualized as being intimately tied to both public and private lives, which advocates say helps politicize instances of violence, and can help mobilize women to take action against IPV. Unfortunately, the radical power of the PCW has been sanitized by many institutions, researchers, and advocates who work in the field of violence prevention. The PCW is often framed as a static, explanatory device, and removed from its context of origin, in which it was generated by a small community of IPV survivors, using Paolo Freire's methodology of community engagement. The wheel has also been severed from its paired activity, which is included in Appendix C of the manual. This activity, in which the learner situates tactics of power and control inside institutional and community mechanisms and cultural values and beliefs, serves a critical function in contextualizing IPV inside systems of oppression, outside the control of an individual. Thus, the PCW was never meant to explain the nature of violence and abuse for all women. Rather, it is a code, or a conversation starter, to help individuals think about their own personal experiences with violence and the institutional and cultural factors influencing them. In order to ensure the resource is relevant to the specific, local conditions of the lives of the patients seeking care at this clinic, a new code would need to be invented using processes similar to those that generated PCW (Price, 2012).

As such, the PCW is to be used in this clinic setting not as a tool to help explain abuse to patients, but rather as a code to generate discussion and allow patients to name and describe their own unique abuse dynamic, and the way it is situated within various contexts. To achieve its

intended results, the PCW shall be used, either in its published form or as a blank version, alongside its corresponding activity, in a private, protected space, with a facilitator who has been versed in Paolo Freire's critical pedagogy. These exercises may meaningfully take place in a group setting, such as in the proposed in-clinic patient support groups, or, less ideally, in a one-on-one setting, such as during a patient's appointment with the clinic's psychologist.

Strengths

A primary strength of this project is the triangulation of voices that inform the deliverable. By conducting qualitative, in-depth interviews with patients, midwives, and members of the psychologist and social worker team, the manual attends to many more of the relevant perspectives than would have been possible if only one of those groups had been interviewed. The people interviewed are experts in their field, their context, and their own lives, and it is their voices that resound throughout the manual. The recommendations were written with careful consideration of the unique needs and desires of the various stakeholders involved, which makes the product applicable to more individuals and helps achieve buy-in for any quality improvement measures that take place as a result of this work.

Additionally, this project is deeply rooted in the current discussions, recommendations, and resources being implemented in clinical contexts all over the world. This project does not reinvent the wheel. Rather it pulls from many of the well-designed frameworks, resources, and provider-training curriculums on IPV already in existence that can be adapted for this specific context. While this work heavily utilizes existing IPV resources, the nature of the specific population served by this clinic, which is generally very low income, with limited literacy skills and access to technology, limits the feasibility of utilizing some of the newer technologies being

implemented and studied for IPV prevention, such as the iCan Plan 4 Safety app-based safety planning tool (Ford-Gilboe et al., 2020).

Limitations

This project has a number of limitations that relevant parties must be aware of when considering its recommendations. First, due to the language abilities of the researchers and limitations around translation assistance during interviews, all the patients who were interviewed were Spanish-speaking. As a result, the study is missing the critical voices of the Haitian patients who the providers mention frequently. Providers discuss, at length, the unique challenges to providing appropriate, comprehensive IPV care to Haitian women, due to the language barrier, as well as a perceived cultural barrier around the level of IPV normalization in the Haitian community. Due to this gap in data, there are tremendous assumptions made around the utility of the manual's recommendation section to this segment of the clinic's patient population.

Additionally, an American student wrote this manual, with guidance and support from the Chilean research collaborators, that included two experienced Chilean midwife researchers and two Chilean midwifery students. While the project was heavily supported by those with direct experience as providers in the Chilean system of midwifery care, it is likely missing important nuances and intricacies of the Chilean system and model of care that would have been accounted for, had the author been a cultural insider. However, this manual is a living document, and is designed to be a template, a starting place, for further development by leaders and stakeholders inside the CESFAM.

Additionally, this project does not delve into the important work being done on providing trauma-informed care, as the CESFAM is predominantly focused on improving disclosure and IPV-related referral processes at this time. Providing trauma-informed care is critical to

providing high-quality care to patients with current or past exposure to IPV. Thus, the routine implementation of a consistent and high-quality, trauma-informed approach to care by all midwives in the clinic will be an important next step (Sperlich, Seng, Li, Taylor, & Bradbury-Jones, 2017).

Implementation and Evaluation

In order to ensure that any clinic-based changes are sustainably implemented, evidence-based quality improvement methods are recommended. Specifically, the Plan-Do-Study-Act (PDSA) cycle is recommended to ensure that any changes to processes are conducted on a small scale, and then evaluated and refined before adopted by the larger clinic body. This process has been found to improve buy-in of those impacted by the change, and ensure its quality and long-term sustainability (Itri et al., 2017).

Due to the tremendous financial and human resource limitations experienced in this clinic and at other inner city CESFAMs in Santiago, any formal evaluation plans will need to be devised in close collaboration with clinic leadership. The interview transcripts from this project can serve as baseline data around provider beliefs and perceptions around areas for quality improvement around IPV care. Post-implementation interviews with patients and providers may help gauge growth in these beliefs and perceptions around any changes to clinic's IPV process or approach. Data on wait times between referral and appointment for internal IPV resources, the number of patients who follow through on referrals, attendance data from support groups, and the overall level of patient satisfaction of IPV care in the CESFAM could all be useful indicators around the utility and success of any changes to the IPV detection tool, process, or care.

Specifically, if the clinic decides to attempt to minimize the number of referrals made to the CdlM, baseline data on the number of referrals to the CdlM, as well as to internal resources,

happening each week at present would be critical to compare to post-implementation end-line data. It is unclear if the clinic's electronic health record could assist with this data collection. To effectively measure knowledge acquisition of providers from trainings, pre- and post-tests shall be given before and after each training, with another sample of providers tested three months after the training.

Public Health Implications

The nature and tone of this project is a direct response both to the IPV literature around the challenges of implementing clinic-based IPV interventions that impact repeat incidences of IPV, as well as the expressed desires of the clinicians and patients interviewed. Instead of viewing IPV screenings and referrals as a direct means to reducing IPV incidence, this manual takes a long-view of the ways small changes in tone and approach to IPV care in the clinic space can impact patient well-being. These small changes have the power to improve trust building between patient and provider, improve a patient's sense of support and social connectedness, push against the hyper-normalization of non-physical forms of violence and abuse, and build fluency around horizontal power dynamics and help seeking behavior in patients who need it. While it is unclear in the literature if these impacts will decrease future exposure of IPV (Feder et al., 2011; MacMillan et al., 2009; Moracco & Cole, 2009), there is reason to think that such shifts in the clinic's approach to and readiness for care may improve disclosure rates and reduce the rates of provider burn-out (Chisholm, Bullock, & Ferguson, 2017b; Feder et al., 2011; Klevens et al., 2015; Renner et al., 2019). This, in turn, has the potential to improve the mental health of patients, improve birth outcomes, decrease likelihood of adverse childhood experiences around witnessing/withstanding violence, and possibly improve the likelihood of breaking the generational cycle of abuse (Chisholm et al., 2017b). Beyond the potential for improvements in

health, evidence is abundant across studies, and in this project, that patients desire to be screened and to have discussions about IPV with their providers, presumably because of its ability to help someone feel supported and heard in their experience (Fawole, Balogun, Adejimi, Akinsola, & Van Wyk, 2019; Garnweidner-Holme, Lukasse, Solheim, & Henriksen, 2017). The public health implications for meeting such a small need for patient would be hard to measure, but it would be impossible to contest the existence of its value.

Clinical implications include improving the patient experience in the clinic by emphasizing confidentiality, affirming the patient's decisions, and respecting the patient's autonomy in all decision-making around IPV care. Additionally, the approach and process changes pitched are slated to improve the consistency and standard of care through routine training of providers and standardization of competencies and processes. By clarifying the tone and goal of providers around IPV in the CESFAM, and through strengthening provider's abilities to meet the needs of patients, this project hopes to decrease provider burn out, as it pertains to providing care around this complex and highly sensitive issue.

Finally, this project, by affirming and highlighting the providers' and patients' desires for community-wide anti-violence efforts, aims to mobilize the relevant stakeholders to make demands at the public policy level for additional supports for women seeking resources for abuse and address the normalization of violence.

Future Steps and Conclusion

Like all health-systems, it appears that this CESFAM could do more to support their providers in integrating IPV care with support for their patients experiencing postpartum depression, as well as ensuring that all providers are conducting trauma-informed obstetric and gynecologic care for all patients, but especially those with a current or past experience of abuse.

Looking forward, there is an abundance of potential intervention ideas in the literature for the clinic's future consideration. While there is a clear need for additional research around specific interventions and their impacts on various populations (Moracco & Cole, 2009), promising research is exists around some potential clinic-based interventions, such as providing brief, but consistent IPV interventions alongside clinic-based screenings, such as a thirty minute counseling session during pregnancy (Daoud et al., 2020a; Kiely, El-Mohandes, El-Khorazaty, Blake, & Gantz, 2010). Unsurprisingly, interventions appear to have varying effects across racial and ethnic groups, and clinics will need to be mindful of this reality as they tailor approaches and interventions to their specific clients (Daoud et al., 2020b).

Additionally, economic solvency programs also show promise of addressing the structural roots of IPV risk and have been found to be appealing to individuals seeking to escape situations of IPV (Gilroy, Nava, & Ellis, 2019). While it is possible that these topics could be delivered in the IPV support groups proposed, it remains unclear if providing education and support around financial management, job skills, and education is within the scope of what providers and administrators at this CESFAM are able to deliver at this time.

The author hopes that findings from this project's interviews, as well as any subsequent data regarding the implementation of any changes to clinic efforts or procedures, will be made available, presented to, or adapted and scaled up to any of the other CESFAM sites across Santiago. By sharing this work's findings on the current strengths and the areas for growth and improvement in this CESFAM, other locations may make meaningful improvements in their approach and provider training, clinic processes, and community engagement tactics, to the betterment of their patients experiencing violence.

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